STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7509	A. BUILDING: _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An investigation of complaint TN00054018, TN00054415, TN00054526, TN00054670, TN00054690, TN00055118, TN00055242, and TN00054244 was conducted on 9/14/2021 at The Waters Of Smyrna, LLC. No deficiencies were cited for complaint TN00054018, TN00054415, TN00054526, TN00054670, TN00054690, and TN00055118. Health deficiencies were cited in relation to complaint investigation TN00055242 and TN00055244 were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		
N1207	1200-8-6-.12(1)(g) Resident Rights (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103; This Rule is not met as evidenced by: Based on facility policy review, medical record review, review of the facility investigations, and interviews, the facility failed to prevent verbal abuse for 2 of 18 sample residents (Resident #10 and 17).	N1207	N1207 1. Resident # 10 and 17 were assessed by the Director of Nursing/Social worker and referred to psych services to ensure no adverse effects occurred from the incident. The facility conducted a thorough investigation to include, interviews, skin assessments, employee suspension pending Investigative outcome and reported the incident to the Department of Health. 2. The Director of Human Resources audited each employee file to ensure they have received training/in-service on the facility Abuse policy.	10-28-21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE James Williford TITLE Administrator (X6) DATE 10-7-21

James Williford

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N1207	Continued From page 1 The findings include: Review of the facility's undated policy titled, "ABUSE PREVENTION PROGRAM," revealed, "...It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings...Staff members who are suspected of abuse or misconduct shall immediately be barred from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee...Verbal abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability..." Review of the facility's policy dated 11/2016 titled, "Resident Rights Policy," revealed "...A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality..." Review of the completed facility investigation dated 9/1/2021 for Resident #10 revealed the facility conducted skin assessments on residents with a low BIMS (Brief Interview of Mental Status) score and performed resident interviews with residents who had a high BIMS score. Continued review revealed all staff were educated in Abuse and Abuse reporting. Continued review revealed (Graduate Practical Nurse)GPN #1 was suspended pending investigation. Continued review revealed the incident was reported to the	N1207	3. All facility staff were in-serviced by the Administrator regarding the facility Abuse policy. 4. An Abuse training audit will be conducted by the Administrator monthly X 3 months to ensure all new staff have been trained on the facility abuse policy. Concerns will be addressed immediately and findings will be discussed in the Quality Assurance meeting.	10-28-21

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N1207	Continued From page 2 state agency. Review of the completed facility investigation dated 9/8/2021 for Resident #17 revealed the facility conducted skin assessments on residents with a low BIMS score and performed resident interviews with residents who had a high BIMS score. Continued review revealed all staff were educated in Abuse and Abuse reporting. Continued review revealed (agency) (Certified Nurse Aide) CNA #9 was listed as a 'do not return' to the facility. Continued review revealed the incident was reported to the state agency. Review of GPN #1's employee file revealed she had no disciplinary actions on file. Continued review revealed he was not listed on the abuse registry and had recent abuse training on 9/1/2021. Review of CNA #9's employee file revealed he had no disciplinary actions against him. Continued review revealed he was not listed on the abuse registry and had recent abuse training dated 9/1/2021. Review of the medical record revealed Resident #10 was admitted to the facility on 3/18/2021 with diagnoses which included Vascular Dementia, Mood Disorder, and Major Depressive Disorder. Medical record review of a Quarterly Minimum Data Set (MDS) dated 8/2/2021 revealed Resident #10 had a BIMS score of 8 which indicated moderate cognitive impairment. Continued review revealed the resident exhibited verbal behaviors 1-3 days of the 7 day look back period. Continued review required extensive assistance of staff with eating, dressing, and personal hygiene.	N1207		

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N1207	Continued From page 3 Review of the medical record revealed Resident #17 was admitted to the facility on 8/23/2019 with diagnoses which included Cerebral Palsy, Major Depressive Disorder, Personal History of Urinary Tract Infections, and Congestive Heart Failure. Medical record review of the Quarterly MDS dated 7/7/2021 revealed Resident #17 had a BIMS score of 15 which indicated no cognitive impairment. Continued review revealed the resident was frequently incontinent and required extensive staff assistance with toileting. Review of the medical record revealed Resident #18 was admitted to the facility on 10/10/2019 with diagnoses which included Spastic Quadriplegic Cerebral Palsy, Anxiety, and Chronic Obstructive Pulmonary Disease. Medical record review of the Quarterly MDS dated 7/26/2021 revealed Resident #18 had a BIMS score of 15 which indicated no cognitive impairment. During an interview on 9/1/2021 at 11:53 AM, Certified Nursing Assistant (CNA) #2 stated she was changing Resident #10 and the resident always screamed out during care. Continued interview she stated, "someone came to his door and told him to 'stop that,' they had visitors in the building." During continued interview she stated she did not tell the resident to 'stop that' and she didn't know who the staff was that came to the door and told the resident to stop that." During an interview on 9/1/2021 at 2:46 PM, GPN #1 stated she was assigned to the 100 hall this date and had been employed at the facility for 3 months. During continued interview she stated	N1207		

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N1207	Continued From page 4 "[named] Resident #10's door was cracked open, and he was yelling at the aide while she was providing care for him; I went into the room and told the resident to "stop that" because we had visitors in the building." During an interview on 9/2/2021 at 3:15 PM, the Administrator stated "what [named] GPN #1 said to Resident #10 was inappropriate and poor judgement." He confirmed "an example of verbal abuse would be to tell a resident to shut up or to "stop that." During an interview on 9/14/2021 at 12:28 PM with Resident #17 she stated "about a month ago I needed to go to the bathroom; it was around lunch time, I was having trouble with my bladder and wet on myself. [named] Certified Nursing Assistant (CNA) #9 came into my room with an attitude and was rude to me and said, "Why didn't you call me to go to the bathroom." Continued interview she stated, "the 2nd time I had to go to the bathroom a few hours later, I wet on myself again and he [CNA #9] said "why did you do that, why didn't you call?" Continued interview she stated, "I was so mad I started crying and I told him he was being a "smart ass" and I reported it to [named] Nurse, he got close to my face and said 'sarcastically', I don't have to listen to what [named] Nurse said; then he started being nice to me." She stated, "he hasn't taken care of me since." During an interview on 9/14/2021 at 4:18 PM the Director of Nursing confirmed she substantiated the allegations of verbal abuse for Residents #10 and #17 through resident and staff interviews. Continued interview she confirmed GPN #1 was suspended and would be terminated, and CNA #9 would not be able to return to the facility.	N1207		

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N1207	Continued From page 5 During an interview on 9/14/2021 at 2:40 PM, Resident #18 stated when she called CNA #9 into the room to assist her with toileting her room mate also needed assistance with toileting and CNA #9 was rude and got in her roommates face and told her the nurse wasn't in charge of him and he didn't have to listen to her. During an interview on 9/14/2021 at 1:21 PM, Temporary Nurse Aide (TNA), stated Resident #17 told her an agency CNA refused to change her and refused to take her to the bathroom. During further interview she stated Resident #17 told her CNA #9 had got in her face and yelled at her and told her he wasn't going to change her. During further interview she stated Resident #18 was Resident #17's room mate and was in the room when Resident #17 told her about what happened and Resident #18 confirmed what Resident #17 had said did happen.	N1207		